Policy and Procedure Milwaukee County Behavioral Health Division SAIL	Date Issued 6/14/2000	Section Community Services	Policy Number QA-5	Page 1
	Date Revised 7/25/2012	Subject: Death Reporting		

1. POLICY:

PURPOSE: To be informed of and monitor client deaths in Community Services Branch programs, both Division-operated and Provider Network agencies, for purposes of ongoing quality assurance and performance improvement.

POLICY: The Behavioral Health Division (BHD) shall be informed in writing and by phone contact of any death of a client in service in Community Services Branch Division-operated and Provider Network agencies within 24 hours of discovery of death, on the first business day following the death.

2. PROCEDURE:

A. Programs are to notify BHD Community Services Branch, care of Service Access for Independent Living (SAIL) of any death of a client in service within 24 hours of discovery of the death, on the first business day following the death.

B. **BHD-operated programs** are to complete and submit the following forms:

1. Notification of Death Form to SAIL, within 1 business day of discovery of the death.

2. Incident/Risk Management Report (MCBHD Form 4310-latest draft) to Quality Management and a copy to SAIL.

3. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). The Standard of Practice for BHD- operated programs has been to complete this form and notify the State on all deaths that occur in any of the BHD-operated programs. A copy of the Client/Patient Death Determination Form DSL-2470 should be forwarded to the BHD SAIL Program.

4. Other Notifications: each BHD Operated Program will notify the Community Services Branch Director, the Manager of Medical Records, the Service Manager for the designated service area, and the Behavioral Health Division Administrator, in the event a death occurs in the respective program.

C. **BHD-Provider Network agencies** are to complete and submit the following forms:

1. Notification of Death Form to SAIL, within 1 business day of discovery of the death.

2. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). A copy of the completed form should be forwarded to BHD SAIL Program.

3. A Copy of Coroner/Medical Examiner's report to SAIL when available.

4. Other Notifications: each BHD Provider Network Agency will notify the Service Manager for the designated service area in the event a death occurs in the agency.

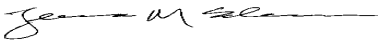
D. **Quality Assurance Process**

1. BHD Community Services Branch Provider Network agencies are to have a quality/risk management process in place for internal review of client deaths. Following the death of a client, the agency is to complete their internal review and submit a brief written summary of findings. This summary may include: treatment and service delivery at time of death, evaluation of those services, and recommendations for changes in services or treatment. This summary is to be sent to BHD Community Services Branch, care of SAIL program- Quality Assurance.

2. BHD-operated programs are subject to the existing BHD Quality/Risk Management policy and procedure governing critical incident review.

3. BHD Community Services Branch, through Program Service Managers, will review the reports of client deaths and forward problematic cases to the BHD Critical Incident Committee.

4. BHD Community Services Branch reserves the right to explore all reports of client deaths.

Reviewed & Approved by: 

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Adult Community Services Branch

Attachment

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Wauwatosa, WI. 53226
Community Services Branch
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NOTIFICATION OF DEATH

Discharge request from SAIL: ___ TCM ___ CSP ___ CBRF ___ DTM ___ THP ___ OP
WIser Choice: ___ RSC/CMASS ___ Residential ___ Day Treatment ___ Outpatient ___ Ancillary
(WIser Choice agencies still need to complete the Discharge Form, except Ancillary providers)

Consumer: _____ **MR/Client #:** _____

Gender: □ Male □ Female Date of Birth:_____ Age:_____

RU#:_____ Provider Agency: _____

Agency Admission Date: _____ Agency Contact & Phone #: _____

Date of Death (If Known):_____ Date of Agency's Discovery of Death: _____

Cause of Death (If Known): □ Natural □ Suicide □ Homicide □ Unknown □ Other _____

I. Circumstances of Death (location, anticipated/unanticipated): _____

Describe Actions Taken: _____

Notifications Made:
_____ Coroner / Medical Examiner
_____ Sheriff / Police
_____ State of WI DHSS Client/Patient Death Determination
(Please attach copy of completed form)

II. Diagnoses

Axis I. _____

Axis II. _____

Axis III. _____

III. Current Behavioral Health Condition / Treatment

A. List of Most Recent Medications: _____

Medications Changes within the Last Seven Days: _____

B. Current Service Delivery (Include Frequency, Intensity, Type and Date of Last Contact): _____

C. Describe any Significant Changes in Client's Behavioral Health in the Last Month based on Observed or Reported Symptoms and Behaviors: _____

D. Any Evidence that Client was Having Suicidal Thoughts in the Last Month? (If Yes, Please Explain):

_____

_____

_____

_____

IV. Other Factors

A. Medical / physical health problems (If Known): _____

_____

_____

_____

Last medical appointment (If Known): _____

B. Self care / Community Living Problems (Include safety, nutrition, judgment, vulnerability): _____

_____

_____

_____

C. Risk behaviors (Include self-harm, suicide, dangerousness to self and/or others, substance abuse, antisocial, criminal): _____

_____

_____

_____

_____ _____ _____

Name of Staff Reporting Signature Date

_____ _____ _____

Name of Clinical Supervisor Signature Date

For Community Service Branch use only:

Impression: _____

_____

_____

Recommendations: _____

_____

_____

SAIL Service Manager _____ **Date** _____

signature